

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/14/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 290019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2009
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NAME OF PROVIDER OR SUPPLIER CARSON TAHOE REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 MEDICAL PARKWAY CARSON CITY, NV 89703
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A 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Full Medicare survey initiated on March 30, 2009 and completed on April 8, 2009. The facility was found to be in compliance with all Conditions of Participation. There were standard level deficiencies identified. Two State Licensure complaint surveys were also conducted: Complaint #NV00021145 was substantiated with deficiencies cited. Complaint #NV00021177 was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	A 000		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on interview and documentation, the facility failed to have the governing body approve the grievance policy and procedure.	A 119	<p>RECEIVED JUL 10 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA</p> <p>A119 - RESPONSE: To formalize the current process, a Board Resolution delegating the responsibility for the handling of complaint/grievances to the Grievance Committee was drafted by the Patient Relations Manager and signed by the CEO on 6/18/2009. The Resolution is on the agenda for the August 6, 2009 Board of Hospital Trustees meeting.</p> <p>The Patient Complaint/Grievance policy has been revised to match the proposed resolution delegating responsibility to the Grievance committee. Once the resolution is approved by the Board in August, the policy will be finalized and approved, reflecting the date the board acted on the resolution. The revised policy outlines that the Grievance Committee membership consists</p> <p>(continued on next page)</p>	

ABOARDATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cathy Drauer</i>	TITLE CNO	(X6) DATE 6-18-09
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

<i>Cathy Drauer</i>	CNO	7-10-09
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A 119	Continued From page 1 Findings include: Review of the grievance policy titled "Patient Complaints/Grievances" effective March 1, 2009 revealed that there was no approval process of the policy or procedure for grievances by the governing body. Interview with the Ombudsman, Risk Manager, and Quality Improvement coordinator on 3/31/2009 confirmed that although the governing body received reports on a quarterly basis of the grievances received by the facility, they did not approve the policy/procedure.	* A 119	A 119 (continued) of the Ombudsman (Patient Relations Manager), Director of Quality, Risk Manager, and the appropriate Nurse Manager form the ad hoc committee depending upon the department/unit involved. The Grievance Committee meets as needed for the review of individual complaints and bi-annually to review overall trends. Patient Relations Manager maintains meeting minutes and a data base for the purpose of tracking the complaint/grievance review process.	
A 133	482.13(b)(4) PATIENT RIGHTS: ADMISSION STATUS NOTIFICATION The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital. This STANDARD is not met as evidenced by: Based on medical record review and interview with the managers of several nursing units, the facility did not contact the patients' family members or representatives and did not notify the patients' physician of the patients' admission to the hospital. Findings include: Review of patient records admission sheets that were utilized through the medical oncology unit and the telemetry unit revealed that "next of kin" was noted. However, there was no indication that the patient was asked if they wanted to have the facility notify their "next of kin" of their admission. Also the admission form did not indicate whether	A 133	A 133-Reviewed by Nurse Manager of the Medical/Oncology Unit. -The Nursing Admit History & Physical form will be revised by Med/Onc Nurse Manager to include the questions: 1. Do you want us to notify your next of kin? 2. Who is your primary physician? 3. Do you want them notified that you are in the hospital? -The Admitting RN will ask the questions and make the notifications. -Nursing Admit History & Physical Form will be revised and to the printer by 06/30/09. (There is a 2 week turn-around time with vendor.) -Nurse Department Managers will complete Staff education and initiate new form by 7/31/09. Education accomplished by staff meetings, communication book, and one on one. (continued on next page)	

* 7/9/09 A119 Patient Relations manager has ultimate responsibility for process, follow up and monitoring.

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A 133	Continued From page 2 their own physician was notified. Review of patient records would randomly state that "family members present on admission" but no consistent system was in place to assure that patients were being asked if they wanted to have the facility notify the notify a family member or representative or their own physician. Interview of the managers of the Medical/Oncology unit on 3/31/2009 and the manager of the Intensive Care units revealed that the staff did ask for "next of kin" information, however they did not ask if the patient wanted them notified if they were not present. Interview also confirmed that the patient's physician were not notified on a consistent basis. They did state, that some of the hospitalists (physician's who see patients during their hospital stay) did notify the patients' primary physician but not all of them.	A 133	A 133 (continued) Monitoring: 1. This piece will be added to the current chart review on admission documentation. 2. Compliance with documentation will be monitored by Nursing managers and Health Information Management.	
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on clinical record review, interview and facility policy review, the facility failed to ensure that physical restraints, specifically a Posey vest restraint and soft limb restraints were used only after less restrictive interventions had been determined to be ineffective to protect a patient from harm, in 1 of 34 patients (#1) Findings Include:	7/9/09 A 164	A133 Director of med onc, Surg Ortho, TELE, women Childrens has ultimate responsibility for implementation, compliance and monitoring A 164 RESTRAINTS - 482.13(e) -Restraint policy, findings from the State and Standards were extensively reviewed by the Medical/Oncology Nurse Manager - originator of the Restraint Policy. -The current policy dated November 2007, was in compliance with the CMS standards on Restraint/Seclusion Use except for the Physician Education requirement. This will be added to the policy by June 26, 2009. The need for reinforcement of nursing education on the policy and standards was identified. -Med/Onc Manager will meet with the Nursing Manager Team on June 23, 2009 (at monthly manager meeting) to review and discuss findings and educational requirements. Educational outline will be presented. -Educational packet will be finalized (after manager input) by June 30, 2009. -Nursing will re-take the restraint (continued on next page)	

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A 164	<p>Continued From page 3</p> <p>Patient #1 was a 50 year old female, who presented to the emergency room by ambulance on 1/11/09, with the primary complaints of seizures, and injury to the tongue. Patient #1 was triaged on arrival at 12:40 PM, where it was determined she was alert and oriented, but could not recall events. She had blood around her mouth and her tongue was swollen at the tip. She was shaking and confused and her husband was at the bedside. At 1:30 PM, Patient #1 had another seizure. At 2:30 PM, she became confused, pulling out her intravenous needle and trying to get out of bed. She was medicated with Ativan and the intravenous line (IV) was restarted. It was documented that the Ativan was effective. There were no other entries that Patient #1 was pulling at the IV or exhibiting any other behaviors that could cause harm.</p> <p>At approximately 3:00 PM, the emergency room physician ordered a Posey vest restraint. He identified that the conditions requiring the restraints were Patient #1's: inability to follow instruction, she was confused/forgetful, her judgement was impaired, she was removing intravenous lines, she was agitated and confused and forgetful or non-compliant. This order also included a pre-typed statement "Alternative measures considered and not feasible or attempted and not effective." This statement was signed by the registered nurse, but it did not indicate what measures were considered or attempted. There was no specific documentation that any alternative measures were attempted in the narrative emergency nurse's notes. Patient #1 remained in the emergency room approximately three and one half hours and then transferred to ICU.</p>	7/9/09	<p>A 164 (continued)</p> <p>module in SWANK (as a review) and complete the new educational packet by July 30, 2009.</p> <p>-Monthly chart reviews/audits are currently being completed by the nursing managers. Areas identified for improvement will be added to these reviews for restraint documentation compliance.</p> <p><i>Director of ICU and ED has ultimate responsibility to implement and monitor.</i></p> <p><u>RESTRAINT EDUCATION HIGHLIGHTS:</u></p> <p>-Restraints were used only after less restrictive interventions have been determined to be ineffective to protect the patient from harm.</p> <p><u>-DOCUMENTATION:</u></p> <p>-Restraints must be documented in the admit nurse's notes. Patient transfers from unit to unit - restraints need to be addressed in initial note.</p> <p>-Type and location of restraints must be documented a minimum of once a shift.</p> <p>-The rationale for restraints will be assessed on an ongoing basis and documented at least once per shift.</p> <p>-Alternatives will be documented once per shift.</p> <p>-Medications given - need to document if they were effective or not.</p> <p>-Family education - explain what lead to restraint being utilized and how they can assist in keeping the patient out of restraints.</p> <p>-Patient plan of care must reflect the use of restraints.</p> <p>-Physician orders must be current per policy. (continued on next page)</p>	

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A 164	<p>Continued From page 3</p> <p>Patient #1 was a 50 year old female, who presented to the emergency room by ambulance on 1/11/09, with the primary complaints of seizures, and injury to the tongue. Patient #1 was triaged on arrival at 12:40 PM, where it was determined she was alert and oriented, but could not recall events. She had blood around her mouth and her tongue was swollen at the tip. She was shaking and confused and her husband was at the bedside. At 1:30 PM, Patient #1 had another seizure. At 2:30 PM, she became confused, pulling out her intravenous needle and trying to get out of bed. She was medicated with Ativan and the intravenous line (IV) was restarted. It was documented that the Ativan was effective. There were no other entries that Patient #1 was pulling at the IV or exhibiting any other behaviors that could cause harm.</p> <p>At approximately 3:00 PM, the emergency room physician ordered a Posey vest restraint. He identified that the conditions requiring the restraints were Patient #1's: inability to follow instruction, she was confused/forgetful, her judgement was impaired, she was removing intravenous lines, she was agitated and confused and forgetful or non-compliant. This order also included a pre-typed statement "Alternative measures considered and not feasible or attempted and not effective." This statement was signed by the registered nurse, but it did not indicate what measures were considered or attempted. There was no specific documentation that any alternative measures were attempted in the narrative emergency nurse's notes. Patient #1 remained in the emergency room approximately three and one half hours and then transferred to ICU.</p>	A 164	<p>A 164 (continued)- Page 4 of 31 (continued)</p> <p><i>7/7/09 Appropriate chart documentation found in chart</i></p> <p>Pre-restraint alternative measures that were tried were listed on the Nursing documentation form:</p> <ol style="list-style-type: none"> 1. Problem solving 2. Talk/de-escalation less than 30mins. 3. Pharmacological review 6. Bed in low position 7. Gauze/wrap to hide tubes 8. Reorientation 9. Redirect focus 10. Lab value review 11. Modify environment 15. Pain control 17. Increased observation 	

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A 164	<p>Continued From page 4</p> <p>There was no documentation in the narrative admission notes at 5:00 PM on 1/11/09, by the ICU nurse that Patient #1 was restrained. An entry at 7 PM on 1/11/09, indicated that soft limb wrist restraints were placed on Patient #1 because "patient restless, as she became agitated shouting and attempted to climb out of bed and pull at the IV lines". Physician orders indicated that Ativan and Valium were to be used for behaviors and alcohol withdrawal symptoms. The medication record revealed that these were given, but no documentation was evident to demonstrate these were effective enough to remove the restraints.</p> <p>The physician's dictated history and physical on 1/11/09, indicated Patient #1 had two more seizures in emergency. Patient #1 was also having nausea and vomiting. She was diagnosed as having severe alcohol withdrawal. This was dictated at 3:40 PM on 1/11/09. There was no documentation in the history and physical or the physician progress notes that Patient #1 required restraints due to behaviors.</p> <p>Review of the facility restraint policy, last reviewed 11/2007, described the various specific alternatives that could be chosen instead of restraints. These include having the family assist with companionship and supervision, re-orient the patient to their surroundings, assess for pain or discomfort, or cover IV sites with a protective wrap. There was no evidence in either emergency room or ICU documentation that any of these alternatives were attempted.</p> <p>A phone interview with the husband of Patient #1 was conducted on 3/31/09. He acknowledged that his wife had been restrained. He did not</p>	7/9/09	<p>A 164 (continued)</p> <p>See Nursing Education Plan <i>previous</i> <i>See A164 page 4 of 31</i></p> <p>See previous and following Restraint Comments- <i>page 4 of 31 Appropriate</i> <i>documentation in chart</i> Regarding specific alternatives and documentation found in chart by Nurse Manager of Med/Onc.</p>		

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A 164	Continued From page 5 recall any staff instruction to either him or his wife regarding alternatives to the restraints, such as when he was there, the restraints could be removed if he could monitor his wife's actions. An interview with the ICU charge nurse and an ICU registered nurse on 3/31/09, confirmed the hospital has staff that were used as sitters to assist with alternative interventions, but confirmed that there was no way to check to see if sitters had been requested. The also confirmed that the ICU documentation did not include any alternative measure effectiveness.	A 164	ICU Manager has conducted complete chart reveiw, has discussed with specific staff involved, and agendized issues for ICU staff meeting scheduled July 15, 2009 and Charge RN Meeting on July 8, 2009.-ICU Manager and ICU Charge RN's conduct monthly restraint audits and will monitor areas specific to application/release and alternative measure effectiveness. Findings to be discussed with specific staff involved as appropriate.	
A 165	Cross refer: A0165, A0166, A0167, and A0168 482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based on clinical record review, interview and facility policy review, the facility failed to ensure that the type of restraints were the least restrictive and that there was no order for the soft wrist restraints for 1 of 34 patients (#1) Findings Include: Patient #1 was a 50 year old female, who presented to the emergency room by ambulance on 1/11/09, with the primary complaints of seizure, and injury to the tongue. It was documented that she had another seizure at 1:30 PM. At 2:30 PM, the documentation indicated that Patient #1 was confused and pulled out her	7-7-09 A 165 7-7-09	ICU manager has ultimately responsibility for above A 165 See Nursing Education Plan in previous comments. See page 4 of 31 @ A164	

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A 165	Continued From page 6 intravenous line (IV). Patient #1 was also attempting to get out of bed. She was medicated with Ativan and the IV was restarted. It was documented that the Ativan was effective. At approximately 3:00 PM, the emergency room physician ordered a Posey vest restraint. Patient #1 was transferred to the intensive care unit at 4:40 PM. The entry on 1/11/09 at 7 PM indicated that soft limb wrist restraints were placed on Patient #1, because "patient restless, as she became agitated shouting and attempted to climb out of bed and pull at the IV lines." The Posey vest restraint was still in place. There was no evidence that the primary physician was informed that Patient #1's behaviors required additional restraints. There was no order for the soft wrist restraints. An interview with the ICU nurses who participated in Patient #1's care during this time interval revealed that the nurses did not recall this patient.	A 165 7-7-09	A165 See Nursing Educational Plan Previous comment See page 4 of 31 @ A164		
A 166	Cross refer: A0164, A0166, A0167, and A0168 482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, interview and facility policy review, the facility failed to ensure that physical restraints, specifically a Posey vest restraint and soft limb restraints were used in accordance with a written modification to the patient's plan of care in 1 of 34 patients (#1)	A 166 7-7-09	A 166 See Nursing Educational Plan previous comments. see page 4 of 31 @ A164		

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A 166	<p>Continued From page 7</p> <p>Findings Include:</p> <p>Patient #1 was a 50 year old female, who presented to the emergency room by ambulance on 1/11/09, with the primary complaints of seizures, and injury to the tongue. She had blood around her mouth and her tongue was swollen at the tip. Patient #1 had another seizure at 1:30 PM. At 2:30 PM, the documentation revealed that Patient #1 was confused and pulled out her IV. Patient #1 was also attempting to get out of bed. She was medicated with Ativan and the intravenous line (IV) was restarted. It was documented that the Ativan was effective. At approximately 3:00 PM, the emergency room physician ordered a Posey vest restraint. He identified that the conditions requiring the restraints were Patient #1's: inability to follow instruction, she was confused/forgetful, her judgement was impaired, she was removing intravenous lines, she was agitated and confused and forgetful or non-compliant.</p> <p>Patient #1 was transferred to the intensive care unit. The ICU entry on 1/11/09 at 7:00 PM indicated that soft limb wrist restraints were placed on Patient #1, because "patient restless, as she became agitated shouting and attempted to climb out of bed and pull at the IV lines."</p> <p>An interview with the RN case manager and ICU RN department manager on 3/30/09, confirmed that the plan of care was initiated 1/11/09, revealed that the admitting nurse identified airway protection and alteration of comfort as a problem. There was no documentation to indicate that Patient #1 had a minimum of two seizures that day, that she was in a Posey vest restraint and</p>	A 166	See previous comments.	

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A 166	Continued From page 8 soft limb wrist restraints and that she was exhibiting some confusion or was forgetful. There was no documentation that her airway protection should have identified: 1) she had bitten her tongue resulting in swelling, bruising and bleeding, or; 2) that she had vomited several times in the emergency room. The care plan did not specifically address that because of Patient #1's confusion, tongue injury and recent vomiting, and the restrictions of the Posey vest and the limb restraints, that she was at risk for aspiration because of her limited mobility. The care plan was not revised until 1/13/09 when a nurse added "potential for injury; diagnoses Alcohol seizures" and "alternation in neuro status related to new seizures". The clinical record revealed that Patient #1 was discharged home on 1/13/09. An interview with the ICU charge nurse and an ICU nurse on 3/31/09 acknowledged the plan of care did not address Patient #1's specific needs in a timely manner.	A 166	See Nursing Educational Plan. See previous comments.		
A 167	Cross refer: A0164, A0165, A0167, and A0168 482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on facility policy review, clinical record review, and interview, the facility failed to ensure that physical restraints, specifically a Posey vest	A 167			

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NAME OF PROVIDER OR SUPPLIER CARSON TAHOE REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 MEDICAL PARKWAY CARSON CITY, NV 89703		
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A 167	<p>Continued From page 9</p> <p>restraint and soft limb restraints were implemented and used in accordance with safe and appropriate restraint techniques as determined by hospital policy in accordance with State law for 1 of 34 patients (#1)</p> <p>Findings Include:</p> <p>A review of the facility's policy for restraints, revised November 2007, described that the type and location of the restraining device</p> <ol style="list-style-type: none"> 1) Will be documented at least once per shift and when changed. 2) The rationale for the restraint will be assessed on an ongoing basis and documented at least once per shift 3) Alternatives will be documented once per shift 4) Other monitoring activities will be completed a minimum of every two hours and documented. <p>This policy also described the various specific alternatives that could be chosen instead of restraints. These include having the family assist with companionship and supervision, re-orient the patient to their surroundings, assess for pain or discomfort, or cover IV sites with a protective wrap. There was no documentation that any of these alternatives were attempted.</p> <p>Patient #1 was a 50 year old female, who presented to the emergency room by ambulance at 12:40 PM on 1/11/09, with the primary complaints of seizures, and injury to the tongue. Documentation indicated Patient #1 had another seizure at 1:30 PM and at 2:30 PM, she was confused and pulled out and was attempting to get out of bed. She was medicated with Ativan and the intravenous line (IV) was restarted. It</p>	A 167	<p>1 & 2 Added to Nursing Educational Plan. See previous comments. <i>Page 4 of 31 @ A164</i></p> <p>3. Per the "Restraint Documentation Form" alternatives to restraints were documented every 2 hours.</p> <p>4. Per the "Restraint Documentation Form" other monitoring activities were documented every 2 hours. (1500 on 1/11/09 through 0700 on 1/12/09) (Fluids offered, release & ROM of limbs, toileting offered, circulation assessed & skin intact)</p>		

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A 167	<p>Continued From page 10</p> <p>was documented that the Ativan was effective. There were no other entries that Patient #1 was pulling at the IV or exhibiting any other behaviors that could cause harm.</p> <p>At approximately 3:00 PM, the emergency room physician ordered a Posey vest restraint. Patient #1 was transferred to the intensive care unit. Review of the ICU narrative documentation at 5:00 PM on 1/11/09, revealed there was no indication of the presence of restraints upon arrival in the ICU. At 7:00 PM, the second shift nurse documented that "Patient with Posey vest and soft wrist restraints in place because patient becomes agitated, shouts, and attempts to climb out of bed and pull at lines". There was no further documentation regarding Patient #1's behaviors, responses to treatments or need for ongoing restraints for the rest of the shift which ended at 7:00 AM 1/12/09. Narrative charting for 1/12/09, revealed that at 7:00 AM, Patient #1 had the wrist restraints and the Posey vest still on. Documentation for the next 24 hours revealed no further documentation of any restraint or change.</p> <p>A Restraint Documentation form indicated that Patient #1 was listed as a Criteria 1 need for restraints. A Criteria 1 indicated that the restraints were for medical reasons. This form used a number system identified on the back of the sheet to indicate what pre-restraint measures were used, but it did not indicate whether these were effective at times. There was no indication on 1/11/09 or 1/12/09, that the limb restraints were removed to provide range of motion. There was no evidence that the restraints were ever removed in a trial release, although the form included these prompts. The form did include an entry on 1/12/09, in the space for 9-11 AM "off</p>	A 167	<p>See Nursing Educational Plan</p> <p>-Per documentation on the "Restraint Documentation Form" between 1900 and 0700 stated that there were 4 trial releases completed. If they were successful, the restraints would have been discontinued. If unsuccessful, restraints are continued. Documentation showed the restraints were continued.</p> <p>Documentation on the "Restraint Documentation Form" showed that both limbs were released & ROM completed once every two hours. Trial releases were completed 4 times. Toileting needs were addressed q 2 hours. Circulation and skin integrity were assessed every two hours.</p>	
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A 167	<p>Continued From page 11 ER cord".</p> <p>On 3/31/09, an interview with an ICU registered nurse confirmed it was her entry. She recalled the restraints were removed (off) and she applied an ER cord to Patient #1. An ER cord was similar to a bed/chair alarm to alert staff if a patient tried to get out of bed unassisted. She confirmed there was no further documentation or any evidence that Patient #1 had been monitored to ensure that the ER cord was sufficient and that Patient #1 did not have any further behavior concerns.</p> <p>Review of the clinical record revealed that an "Alcohol Withdrawal Severity Assessment" was initiated at 5:15 PM. This form identified behaviors, and included the instructions that if "a score was > 5 (greater than five), and the respiratory rate was >12 (greater than 12), Valium was to be administered in a dose prescribed according to the score. This form also instructed the staff that reassessments should be done every 15-30 minutes after each dose of Valium. Once the score was less than five, then the nursing staff were to monitor the patients every two hours while the patient was awake and every four hours if the patient was sleeping. Although this tool was not used for restraint monitoring, it did reveal that Patient #1 received Valium from 5:15 PM on 1/11/09, through 4:15 AM on 1/12/09. This form demonstrated that Patient #1's scores remained at 15 or above until 4:15 AM. Although this form did include some of the behaviors that Patient #1 was exhibiting that required interventions, there was no documentation that Patient #1 was requiring restraints to help assist protecting her from injury because of these behaviors.</p>	A 167	<p>Between 0700-0900 1/12/09, alternative measures initiated and the ER cord was identified as an effective alternative to restraints and restraints were removed during 0900-1100 time frame. In ICU, per standards, each patient is evaluated within an appropriate time frame after interventions are initiated. Also, per standards, the effectiveness of interventions is evaluated in relation to outcomes. If the patients behavior warranted the reapplication of restraints, it would have been documented. The alternative measure "ER Cord" was appropriate. Timing specifically when restraints are removed has been added to Nursing Educational Plan.</p> <p>ICU Manager reveiwed Nursing documentation. Met with specific staff involved and reviewed lapses in documentation. Individual improvement plan includes staff member review of policy regarding alcohol withdrawal and documentation requirements. ICU Manager and Charge RN's will add to monthly chart review audit specific to "Alcohol Withdrawal Severity Assessment" and will review findings with specific staff as appropriate as well as report general findings at staff meetings. Will continue monitoring for 12 months or until improvement achieved.</p>	

7-7-09 ICU Manager has ultimate
responsibility as above

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This form also revealed that the nursing staff did not document the recommended 15-30 minute assessments following Valium administration. At 6:20 PM on 1/11/09, Patient #1 received 7.5 milligrams (mg) of Valium for a score of 18. The next documented assessment was done at 8:40 PM (approximately 2.5 hours later) when Patient #1 received 7.5 mg of Valium for a severity score of 20. This form continued to reveal that Patient #1 received four more doses of Valium throughout the night but there was no evidence of every 15 -30 minute assessments after any of these Valium doses. The last documentation was at 7:00 AM on 1/12/09. Although Patient #1's severity score remained at 8, no Valium was given. It was documented that Patient #1 went back to sleep. There was no further documentation on this form.

There was no documentation anywhere in the clinical record that alternative, less restrictive interventions had been ineffective. There was no documentation to indicate that emergency room staff or ICU staff attempted to re-orient the patient to her surroundings and the effectiveness of this.

The clinical record also revealed that at approximately 9:30 AM on 1/12/09, the primary physician signed an order that the Posey and soft limb wrist restraints were to be continued. This corresponded with the same estimated time that the registered nurse removed the restraints and initiated the ER cord. The registered nurse and the ICU charge nurse were interviewed at 12:00 PM on 3/31/09. They could not explain these event differences, except that it was possible the restraint orders were placed in the chart by the preceding shift and the physician signed them

A 167

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A 167	Continued From page 13 automatically.	A 167		
A 168	<p>Cross refer: A0165, A0166, A0164, and A0168 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>This STANDARD is not met as evidenced by: Based on clinical record review, interview and facility policy review, the facility failed to ensure that physical restraints were ordered by a physician or other licensed independent practitioner who has been trained in the hospital and state regulations regarding restraints in 1 of 34 patients (#1)</p> <p>Findings Include:</p> <p>Patient #1 was a 50 year old female, who presented to the emergency room by ambulance on 1/11/09, with the primary complaints of seizures and injury to the tongue. At approximately 3:00 PM, the emergency room physician ordered a Posey vest restraint. He identified that the conditions requiring the restraints were Patient #1's: inability to follow instruction, she was confused/forgetful, her judgement was impaired, she was removing intravenous lines, she was agitated and confused and forgetful or non-compliant.</p>	A 168	See previous - Restraint Comments	

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A 168	<p>Continued From page 14</p> <p>Patient #1 was admitted to the ICU at 5:00 PM. The entry at 7:00 PM on 1/11/09, indicated that soft limb wrist restraints were placed on Patient #1, because "patient restless, as she became agitated shouting and attempted to climb out of bed and pull at the IV lines." There was no order written for the application of these wrist restraints.</p> <p>An interview with the ICU department manager and the RN case manager on 3/31/09 and 4/1/09, revealed that hospital employed staff were required to participate in two computer module classes; Managing Challenging Behaviors and A Guide to Restraints. The hospital programs indicated that the physicians ordering restraints would "have reviewed the facility's policy and procedures" regarding restraints. The RN case manager confirmed on 4/1/09, that physicians did not receive any training regarding the facility's policy and procedure regarding restraints. Neither she nor the ICU department manager could explain why there was no order for the soft limb wrist restraints applied in ICU.</p> <p>Review of the personnel record for the emergency room physician who initially ordered the restraints for Patient #1, revealed no evidence of hospital policy training or review regarding restraints in his record.</p>	A 168	See previous		
A 175	<p>Cross refer: A0164, A0165, A0166 and A0167.</p> <p>482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval</p>	A 175			

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A 175	<p>Continued From page 15 determined by hospital policy.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the hospital failed to train the physicians and the licensed independent practitioners who authorize restrained and seclusion on the use of restraints and seclusion, the hospital's policy for restraints and seclusion, deescalation techniques and alternatives to restraints and monitoring procedures.</p> <p>Findings include:</p> <p>The hospital had two "Swank" programs for training staff on "Restraints" and "Managing Difficult Behaviors. The programs were Internet based. These training programs were provided to staff at initial orientation and annually and more often if identified by their supervisor. This training involved all nursing staff. However, it did not include review by the staff physicians and licensed independent practitioners who would initiate the restraints, monitor the patient for continued needs and order alternatives to the restraints for managing difficult behavior.</p> <p>Random review of the files verified there was no documentation of the physicians receiving training on the different components of the hospital restraint policy, monitoring for continued need for the restraints, or use of alternative to the application of restraints. The lack of physician training was confirmed by the administrative staff and the physician who coordinated physician services.</p>	A 175	<p>The Manager of Medical Staff Services and the Physician Relations Liaison have reviewed and revised the Physician Orientation Packet for 2009 to include components for physicians who authorize restraints. The 2009 packet revisions are available to the July 30 physician orientation. Medical Staff Services Manager will include selected components from the 2009 packet (including but not limited to restraints) in the Medical Staff meeting packets for all committees in July (Medical Staff does not meet in June). Same information is distributed to hospitalists group by the end of June as well as all medical staff who admit to hospital and potentially authorize restraints. Cover letter acknowledging receipt and review by each practitioner is maintained/ monitored by Medical Staff Services Manager in the physician files and delinquencies are addressed thru Medical Staff committees as appropriate. This will be annual requirement as well.</p> <p>7-7-09 Medical Staff Services Manager has ultimate responsibility for monitoring compliance</p>	
A 176	482.13(e)(11) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 176		

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Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

This STANDARD is not met as evidenced by:
Based on interview and review of available documentation, the hospital failed to train the physicians and the licensed independent practitioners who authorize restraints and seclusion on the use of restraints and seclusion, the hospital's policy for restraints and seclusion, deescalation techniques and alternatives to restraints and monitoring procedures.

Findings include:

The hospital had two "Swank" programs for training staff on "Restraints" and "Managing Difficult Behaviors. The programs were Internet based. These training programs were provided to staff at initial orientation and annually and more often if identified by their supervisor. This training involved all nursing staff. However, it did not include review by the staff physicians and licensed independent practitioners who would initiate the restraints, monitor the patient for continued needs and order alternatives to the restraints for managing difficult behavior.

Random review of the files verified there was no documentation of the physicians receiving training on the different components of the hospital restraint policy, monitoring for continued need for

A 176

See previous comments -
Restraint/Seclusion Use policy
has been revised to include Physician
Education and is in approval process.
Final approval - June 26, 2009.

See Page 16 comments and plan

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A 176	Continued From page 17 the restraints, or use of alternative to the application of restraints. The lack of physician training was confirmed by the administrative staff and the physician who coordinated physician services.	A 176			
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that one patient was turned every two hours as indicated in the plan of care to prevent the development of a stage 1 decubitus ulcer for 1 of 34 patients. (Patient #9) Findings include: Patient #9 was seen in the emergency room at 6:10 PM and admitted to the facility on 2/18/09 at 11:55 PM with diagnoses including acute congestive heart failure, acute coronary syndrome, hyponatremia, pneumonia, history of seizure disorder, history of myocardial infarction, weakness, and dysphagia. According to physician orders Patient #9 was to be weighed daily, have a speech, physical therapy, and occupational therapy evaluation, oxygen supplementation, fluid restriction, and strict monitoring of intake and output. The skin/wound screen:skin assessment scale form indicated a score of 13 which was moderate risk. The form indicated the wound care nurse was to be notified for a moderate risk.	A 396	Per letter April 28, 2009 from State of Nevada, Department of Health and Human Services, Health Division, Bureau of Healthcare Quality and Compliance "A complaint investigation conducted at your facility on April 8, 2009 revealed that there were no regulatory deficiencies identified. Therefore, the complaint is unsubstantiated and no further action is required." 4/15/09 7-7-09 See next 5 pages (a,b,c,d,e) for POC submitted for 21145		

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A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that one patient was turned every two hours as indicated in the plan of care to prevent the development of a stage 1 decubitus ulcer for 1 of 34 patients. (Patient #9) Findings include: Patient #9 was seen in the emergency room at 6:10 PM and admitted to the facility on 2/18/09 at 11:55 PM with diagnoses including acute congestive heart failure, acute coronary syndrome, hyponatremia, pneumonia, history of seizure disorder, history of myocardial infarction, weakness, and dysphagia. According to physician orders Patient #9 was to be weighed daily, have a speech, physical therapy, and occupational therapy evaluation, oxygen supplementation, fluid restriction, and strict monitoring of intake and output. The skin/wound screen:skin assessment scale form indicated a score of 13 which was moderate risk. The form indicated the wound care nurse was to be notified for a moderate risk.	A 396 7-7-09	Continued (a) A396 5896 Patient admitted on 2/18/09 at 2355 *Skin and Wound assessment form identified the patient to be an "8" which is a mild risk - wound care nurse not required to be notified for mild risk. (In complaint form from the State, it was stated that the Skin and Wound assessment form indicated a score of "13" which was a moderate risk. The form indicated the wound care nurse was to be notified for a moderate risk.) 2/19/09 at 1620 Patient complained of pain and the RN assessed her and found a reddened area on coccyx with a tiny area of brownish skin - Stage I. 2/19/09 - Night RN assessed patient at 2000 and Stage I wound identified. RN documented in the care plan to assist/provide position changes. 2/20/09-Day RN added turn q2h, keep off wound, to the care plan.	1 1 our : is

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 290019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2009
NAME OF PROVIDER OR SUPPLIER CARSON TAHOE REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 MEDICAL PARKWAY CARSON CITY, NV 89703		
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A 176	Continued From page 17 the restraints, or use of alternative to the application of restraints. The lack of physician training was confirmed by the administrative staff and the physician who coordinated physician services.	A 176 (b) 7-7-09	(continued) 5966 396 2/20/09 - Night RN initialed these interventions. She documented that she observed the patient every 2 hours. - Day CNA initialed "Turned Q2hours" on flow sheet - Night CNA initialed "Turned Q2hours" on flow sheet		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that one patient was turned every two hours as indicated in the plan of care to prevent the development of a stage 1 decubitus ulcer for 1 of 34 patients. (Patient #9) Findings include: Patient #9 was seen in the emergency room at 6:10 PM and admitted to the facility on 2/18/09 at 11:55 PM with diagnoses including acute congestive heart failure, acute coronary syndrome, hyponatremia, pneumonia, history of seizure disorder, history of myocardial infarction, weakness, and dysphagia. According to physician orders Patient #9 was to be weighed daily, have a speech, physical therapy, and occupational therapy evaluation, oxygen supplementation, fluid restriction, and strict monitoring of intake and output. The skin/wound screen:skin assessment scale form indicated a score of 13 which was moderate risk. The form indicated the wound care nurse was to be notified for a moderate risk.	A 396	2/21/09 - Day RN initialed "assist/ provide position changes" (q2h turning was not carried over) - Night RN initialed these interventions and documented that she observed the patient every 2 hours. - Day CNA initialed "Turned Q2hours" on flow sheet - Night CNA initialed "Turned Q2hours" on flow sheet 2/22/09 - Day RN did not initial care plan (assist/provide position changes) - Night RN initialed "assist/provide position changes" - Day CNA initialed "TurnQ2hours" on flow sheet - Night CNA initialed "TurnQ2hours" on flow sheet 2/23/09 - Day RN initialed care plan "assist/provide position changes" Patient discharged at 1430. Findings: - Documentation was inconsistent. - When interviewing the RN's, several stated that if a patient moves themselves about in the bed, they consider that changing position. - There isn't one place to document that the patient was turned and how often.		

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A 176	Continued From page 17 the restraints, or use of alternative to the application of restraints. The lack of physician training was confirmed by the administrative staff and the physician who coordinated physician services.	A 176	(continued) S990 396 Plan of Correction: A. Medical/Oncology Unit 1. During the week of April 20- April 25, Medical/Oncology Manager reviewed complaint and patient chart with the RN's, LPN's and CNA's involved with the care of this patient. Reviewed identified areas of incon- sistent documentation. Discussed importance of clear expectations and documentation of such.		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that one patient was turned every two hours as indicated in the plan of care to prevent the development of a stage 1 decubitus ulcer for 1 of 34 patients. (Patient #9) Findings include: Patient #9 was seen in the emergency room at 6:10 PM and admitted to the facility on 2/18/09 at 11:55 PM with diagnoses including acute congestive heart failure, acute coronary syndrome, hyponatremia, pneumonia, history of seizure disorder, history of myocardial infarction, weakness, and dysphagia. According to physician orders Patient #9 was to be weighed daily, have a speech, physical therapy, and occupational therapy evaluation, oxygen supplementation, fluid restriction, and strict monitoring of intake and output. The skin/wound screen:skin assessment scale form indicated a score of 13 which was moderate risk. The form indicated the wound care nurse was to be notified for a moderate risk.	A 396 7-7-09 (c)	2. Med/Onc Manager individually reinforced and clarified expectations with each staff member (RN, LPN, and CNA) involved with this patient as well as completing individual educa- tion regarding plan of care and documentation. 3. Each RN, LPN and CNA has been assigned the Swank educational module "Documentation/Legal Issues #30206-10". This module will be completed by May 15, 2009. Med/Onc Manager will ensure completion by reviewing certificates of completion in Swank. 4. At the Med/Onc unit staff meeting on May 21, 2009 the Manager will present as chart review the event and issues identified as learning opportunity and reinforcement/ clarification of expectations for all staff. B. House wide - Wound Care Policy 1. Wound care policy and procedure is in the process of being revised. New manager appointed as of March 9, 2009 for the Wound Clinic. New manager, Wound Care RN		

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A 176	Continued From page 17 the restraints, or use of alternative to the application of restraints. The lack of physician training was confirmed by the administrative staff and the physician who coordinated physician services.	A 176	(continued) S300 396 B. House wide-Wound Care Policy (cont'd 1. and Med/Onc Manager involved with the revision as follows: 2. To date: a. The risk assessment tool has been revised. b. The in-patient documenta- tion tool has been developed. c. Wound care products have been reviewed and updated with the assistance of Patient Supplies/ Products Committee. d. Wound care products reference sheet developed by Wound Care RN. e. Cameras will be standardized. Although each unit has cameras, decision was made to standardize cameras accross organiza- tion for consistency and staff use. f. Policy is currently being reviewed and revised by Wound Clinic Manager, Wound Care RN and Med/Onc Manager to include all the changes. g. Implementation for new Wound Care policy and procedures will be implemented on May 18, 2009. House wide nursing education will be completed by May 18, 2009. Education will be on Swank, and live presenta- tions by Unit Managers at staff meetings. C. Hourly Rounding 1. January 2009 - Chief Nursing Office presented to nursing Managers and Directors with information regard- ing concept of hourly rounding housewide for all inpatient units.		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that one patient was turned every two hours as indicated in the plan of care to prevent the development of a stage 1 decubitus ulcer for 1 of 34 patients. (Patient #9) Findings include: Patient #9 was seen in the emergency room at 6:10 PM and admitted to the facility on 2/18/09 at 11:55 PM with diagnoses including acute congestive heart failure, acute coronary syndrome, hyponatremia, pneumonia, history of seizure disorder, history of myocardial infarction, weakness, and dysphagia. According to physician orders Patient #9 was to be weighed daily, have a speech, physical therapy, and occupational therapy evaluation, oxygen supplementation, fluid restriction, and strict monitoring of intake and output. The skin/wound screen:skin assessment scale form indicated a score of 13 which was moderate risk. The form indicated the wound care nurse was to be notified for a moderate risk.	A 396 7-7-09 (d)			

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A 176	Continued From page 17 the restraints, or use of alternative to the application of restraints. The lack of physician training was confirmed by the administrative staff and the physician who coordinated physician services.	A 176	(continued) 2396 396 C. Hourly Rounding (continued) 2. February 2009 - Nursing leaders agreed to adopt hourly rounding concept and began implementation planning.		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that one patient was turned every two hours as indicated in the plan of care to prevent the development of a stage 1 decubitus ulcer for 1 of 34 patients. (Patient #9) Findings include: Patient #9 was seen in the emergency room at 6:10 PM and admitted to the facility on 2/18/09 at 11:55 PM with diagnoses including acute congestive heart failure, acute coronary syndrome, hyponatremia, pneumonia, history of seizure disorder, history of myocardial infarction, weakness, and dysphagia. According to physician orders Patient #9 was to be weighed daily, have a speech, physical therapy, and occupational therapy evaluation, oxygen supplementation, fluid restriction, and strict monitoring of intake and output. The skin/wound screen:skin assessment scale form indicated a score of 13 which was moderate risk. The form indicated the wound care nurse was to be notified for a moderate risk.	A 396 7-7-09 (e)	3. March 2009 - Policy and documentation form (to capture completion of these rounds) was developed. Med/Onc manager presented process at the March 19th staff unit meeting. 4. April 2009 - Documentation form completed and delivered to Med/Onc Manager on April 22, 2009. CNO developed education module for Swank - Education department processing Swank Module. This Swank module will be mandatory for all nursing to complete prior to May 18, 2009. Compliance will be monitored and documented by all unit nursing managers via the Swank program certificates of completion. 5. Hourly Rounding process full implementation (go live) May 18, 2009. Note: Several benefits Patient positioning - One area focused on with hourly rounding is patient positioning. Documentation - Nursing will utilize this new documentation form to capture when the patient is turned and how often. Overall benefits of hourly rounding will include decrease in patient falls and an increase in patient satisfaction.		

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A 396	Continued From page 18 The nursing notes from 2/18/09 indicated the family was staying the night. According to the nursing variance notes on 2/19/09 at 4:20 PM the patient complained that her butt and shoulder hurt. Patient #9 was repositioned and the nurse noted a reddened area on the coccyx with a tiny area of brownish skin. A full skin assessment was done on 2/19/09 at 8:00 PM and a Stage I ulcer was identified on the buttocks. Patient #9 was repositioned at that time with pillows under the legs. It was noted the family was at the bedside. The family was at the patient's bedside twenty four hours per day from admission to discharge. An interview with the family at 9:15 AM on 4/3/09 revealed that there was a family member at the bedside twenty-four hours per day and that the patient was not turned every two hours per the intervention protocol indicated on the flowsheet dated 2/18/09.	A 396		
A 546	482.26(c)(1) RADIOLOGIST RESPONSIBILITIES A qualified full-time, part-time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiological tests that are determined by the medical staff to require a radiologist's specialized knowledge. For purposes of this section, a radiologist is a doctor of medicine or osteopathy who is qualified by education and experience in radiology. This STANDARD is not met as evidenced by: Based on a review of Radiology policies and procedures and staff interview, the medical staff	A 546	Medical Imaging Manager originated a new policy, "Interpretation of Ionizing Radiology Exams" effective June 11, 2009. The policy clarifies that images to be supervised and interpreted by qualified Radiologist or other qualified Practitioner as defined and credentialed by the Medical Staff. In conjunction with the policy, the Clinical Privileges Application form for general surgery and cardiology have been updated by the Medical Staff Services Manager to clarify that interpretation is included.	

7/9/09 Implemented June 11, 2009
Completed June 11, 2009

Medical Staff Services manager
to monitor as appropriate

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A 546	Continued From page 19 had not determined the radiological tests which are required to be interpreted by a radiologist. Findings include: During an interview with the Radiology Manager on 4/3/09, it was determined that the Imaging interpretations read by the vascular surgeons in surgery and the cardiac cath lab, and the cardiologists who read the coronary angiography films were not approved by the medical staff.	A 546	See response, page 19 (A 546)	
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview and policy review, the facility did not ensure food was stored and prepared under sanitary conditions. Findings include: An inspection of the facility's main kitchen on 3/30/09 revealed the following: Food temperatures: Temperatures were taken of foods in the grill refrigerator drawers on 3/30/09 at 10:00 AM, with the following findings: raw chicken (44 degrees F); raw beef (46 degrees F). The dietary manger stated that the kitchen's policy was to maintain refrigerated foods at temperatures below 40 degrees F. She reported that when kitchen staff checked the temperatures of the foods in the grill drawers every morning,	7-9-09 A 749	<i>A 749 Manager of Food and Nutritional Services has ultimate Responsibility as follows:</i> The Manager of Food and Nutritional Services is responsible either directly or indirectly by delegation for the following: On 4/6/09 temperature of the refrigerator was decreased to 30-32 degrees. Temps are now monitored in the am and at each meal = 4 times per day. Temperature record sheets revised to reflect changes. On 3/30/09 slicer cleaned, wrapped in saran and initialed after each use. Can opener pulled daily and washed in dish- washer. The wall behind the slicer cleaned. Immediate correction with removal of pitcher from handsink - responsible employee disciplined for failure to follow established protocols. On 4/1/09 Cappuccino Machine removed from service by Farmer Bros as technology of the equipment causes chutes to soil after single usage. On 4/6/09 policy changed to reflect both the manufactured date and expired date - staff in-serviced on same. Manufactured dated on cottage cheese and cubed cheese - opened dates added this being part of policy.	

On 5/1/09 floor was sealed.

On 4/3/09 Engineering alerted and vent
was cleaned.

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A 749	Continued From page 20 the readings were consistently below 40 degrees F. These foods were not being checked at other times during the day when the grill was being used. Sanitation: The slicer was soiled with deli meats and onions/vegetables; the can opener was soiled; the coffee machine chutes were in need of cleaning; the wall near the slicer was soiled; the handsink near the grill was blocked by a water pitcher, preventing required access for proper handwashing. Food date marking: Sliced meats in the grill refrigerator drawers were dated with an expiration date but not an open date; opened containers of cottage cheese and a bag of cubed mozzarella cheese were not dated. The kitchen's policy was to mark potentially hazardous foods with an expiration (discard) date of five days after preparation or opening. The policy did not address marking these food items with the date of opening or preparation as required to ensure accurate monitoring of discard dates. An inspection of the kitchen at Carson Tahoe Specialty Medical Center on 3/30/09 at 11:30 AM revealed the following: the cement floor of the walk-in refrigerator was porous and in need of sealing; the vent over the dishwashing machine was dirty.	A 749			
A 951	482.51(b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.	A 951	<p>7-7-09 A951 Director of Surgical Services has ultimate responsibility as follows:</p> <p>Correction:</p> <p>-All corrections made are the responsi- bility of the Surgical Services Director. -Immediate actions taken on 3/30/09 when informed of our deficiency by state surveyors include: 1. Discarding the 1000mL sterile water bottle used for irrigation</p>		

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A 951	<p>Continued From page 21</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews, review of the facility's policies and procedures, and review of industry standards of practice the facility failed to ensure that equipment be maintained appropriately, and failed to ensure patient safety for all surgical patients.</p> <p>Findings include:</p> <p>During a tour of the surgical services floor area, a Steris machine was observed to be in use.</p> <p>The Central Processing Coordinator was interviewed on 3/31/09 at 9:25 AM, about routine maintenance and cleaning. She reported that the staff wipes the Steris machine weekly with 70% isopropyl alcohol. She reported that she was not aware of any routine daily maintenance required for the machine.</p> <p>On 3/31/09 at 10:00 AM, the contracted service representative that services the facility's equipment was interviewed and reported that the machine was to be cleaned daily.</p> <p>Review of the facility's central processing and the the routine maintenance of the Steris machine revealed that the manufacturer recommended the following daily cleaning and checks:</p> <p>Step 1: Wipe processor with a soft cloth dampened with 70% isopropyl alcohol of the processing tray. Step 2: Open lid Step 3: Clean processing tray. Flexibie processing tray: Wipe the inner surface and seal, processing tray/container, and accessory rack with a soft cloth dampened with 70% isopropyl</p>	A 951	<p>A 951 (continued)</p> <p>during endoscopy procedures. On a daily basis, the bottle is replaced with a new, unopened 1000mL sterile water bottle labeled with the current date.</p> <p>2. The coiled pediatric endoscope was removed from the drawer. High level disinfected and returned to the storage closet with the distal end hanging freely.</p> <p>3. All peel packed items were inspected in the surgery and central sterile processing department. Any items with watermarks, labeling with ink, or folded inner packages were removed from service and reprocessed in accordance with AAMI Standards 8.3.2 through 8.3.7.</p> <p>4. All surgical and housekeeping staff were instructed to keep OR doors closed at all times except when actively entering and exiting the rooms.</p> <p>-Policy and Procedures New or Revision: All completed and approved by 6/30/09</p> <p>1. Use of Steris Processor (Revision) 2. Cleaning and maintenance of the steam sterilizers in the OR and CS (Revision) 3. Endoscopy reprocessor- Cleaning and maintenance (New) 4. Endoscopy irrigation pump- Sterile water (new) 5. Endoscopes, cleaning and disinfecting (Revision) 6. Fire safety and prevention in the operating room (New)</p>		

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A 951	<p>Continued From page 22</p> <p>alcohol.</p> <p>Step 4. Wipe aspirator assembly and sterilant compartment with a soft cloth dampened with 70 % isopropyl alcohol.</p> <p>Step 5. Check aspirator assembly: probe lumen clear, no cracks or chips, hose connection clear. Replace aspirator assembly if any damage is noted.</p> <p>During a tour of the surgical services and central processing areas on 3/31/09, five autoclaves were observed. The central processing coordinator reported that there were two on the surgical services floor and three in central processing.</p> <p>The Central Processing Coordinator was interviewed on 3/31/09 at 9:25 AM, and reported that the autoclaves in central processing were cleaned weekly and the ones on the surgical services floor were cleaned monthly.</p> <p>Review of the facility's policy and procedure #IC OR, titled: Subject: Cleaning Autoclaves: Effective date 9/30/05, revealed: Policy: "It is the policy of the facility that routine preventive maintenance/cleaning procedures will be completed according to manufacturers recommendations. Sterilizers will be wiped daily and chambers cleaned each week."</p> <p>During a tour of the endoscopy procedure area on 3/31/09, an endoscope reprocessor was observed. The endoscopy charge nurse reported that he was not aware of any daily or quarterly maintenance that needed to be done for the endoscope reprocessor.</p>	A 951	<p>A 951 (continued)</p> <p>7. Surgery-Defining patient safety (Revision)</p> <p>8. Labeling textile and paper/plastic (Steri-peel) packages (New)</p> <p>9. Preparing paper/plastic pouches for sterilization (New)</p> <p>-Additional Measures:</p> <p>1. All affected staff will receive inservices by June 30, 2009 to review policy changes and additions.</p> <p>2. All affected individuals will receive necessary training and education regarding proper daily maintenance procedures for the autoclaves, Steris[®] 1, and endoscope reprocessor June 30, 2009.</p> <p>3. Log books for maintenance documentation were created and made accessible near each piece of equipment described in the deficiency. Staff will be inserviced and begin to use log books by June 30, 2009.</p> <p>-The Surgical Services Director, Clinical Manager, Business Manager, CS Supervisor met to determine all individuals affected by policy and practice changes. The list includes nurses, surgical technologists, OR technicians, instrument technicians, CS technicians, endoscopy technicians, and environmental service technicians.</p> <p>(continued on next page)</p>		

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A 951	<p>Continued From page 23</p> <p>Review of the manufacturer's handbook revealed the following:</p> <ol style="list-style-type: none"> At the end of each day, clean the processing chamber with a chlorine-based agent such as Comet or Ajax and a soft cloth. Simultaneously, press F5 to "empty" the processing chamber, and continue to spray the chamber with water until all residue has been removed. <p>Cleaning the filter screen: This screen acts as a filter to prevent sediment from recirculating through the channels of the device being processed, and must be cleaned on a routine basis.</p> <p>Routine Maintenance Procedure: To maintain your endoscope processor system in optimal condition, routine maintenance procedures must be performed on a quarterly basis.</p> <ol style="list-style-type: none"> Inspect interior of the system for visible leakage. If leakage is apparent, locate the source of the leak and repair. Check filter screens and hoses for wear. Replace as needed. Clean all the solenoid housings and diaphragms per instructions in the bio-medical manual. Inspect impellers for foreign objects. Check all the compression fittings. Check hand spray tubing, handle and fittings for leakage and wear. Check plumbing unions in the disinfectant feed, return, and drain lines. Check purge pumps to the counter top manifold to insure coil is secure. Check military connector to ultrasonic generator from transducer on the bottom of the 	A 951	<p>A 951 (continued)</p> <p><u>Monitoring:</u> -Monitoring of the corrective action will occur as follows:</p> <ol style="list-style-type: none"> The Director of Surgical Services will oversee that all revised and new policies are followed as evidenced by: <ol style="list-style-type: none"> Unannounced review of maintenance log books. Unannounced observations of staff compliance to policies. 		

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A 951	<p>Continued From page 24</p> <p>ultrasonic chamber. Check the ground lug on the transducer plate located next to the gray shielded cable to the generator.</p> <p>16. Clean the front and rear louvers of the generator enclosure.</p> <p>17. Check and secure all four (interface) plugs.</p> <p>18. Check the drain and residual drain hoses for wear at the site of the standpipe.</p> <p>19. Check the movement of the circuit breaker, and inspect the hospital grade plug.</p> <p>20. Check and clean the shafts of the floats</p> <p>21. Check and clean the shaft of there float.</p> <p>22. Locate and remove the filter screen, and replace...</p> <p>On 3/30/09 at 9:00 AM, an endoscopy procedure was observed. After the procedure an irrigation bottle of 1000 milliliters of sterile water was observed to be connected to a pump. The endoscopy charge nurse was asked how often the irrigation bottle and tubing were changed, and he reported that the tubing was changed at the end of the day, or every 24 hours. He further reported that the bottle was emptied at the end of the day, rinsed and then refilled with tap water in preparation for the following day.</p> <p>Review of the pumps operator manual revealed that the bottle was to be changed "after clinical use."</p> <p>On 3/30/09 at 11:15 AM, a clinical representative for the manufacturer was interviewed and reported that single use irrigation bottle was to be discarded daily and replaced with a new sterile water bottle, or a reusable bottle may be used but must be high-level disinfected daily. She reported that the use of tap water was never</p>	A 951			

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A 951	<p>Continued From page 25 recommended.</p> <p>On 3/30/09 at 11:40 AM, an endoscopy tech was observed coiling a pediatric endoscope in a drawer for storage after processing.</p> <p>The endoscopy technician was interviewed on 3/30/09 at 11:40 AM, and reported that the endoscope was being placed in the drawer so that it could be easily accessed if needed. He reported that he had forced compressed air through the endoscope to facilitate drying, but that there was residual moisture in the scope at the time that it was placed in the drawer.</p> <p>Review of the manufacturer's endoscope reprocessing manual, revealed: Caution: -The storage cabinet must be clean, dry, well ventilated and maintained at ambient temperature. Storing the endoscope in direct sunlight, high humidity or exposed to x-rays may damage the endoscope or present an infection control risk. -Do not store the endoscope in the carrying case... Routinely storing the endoscope in a humid, non-ventilated environment such as the carrying case may present an infection control risk.</p> <p>5. Hang the endoscope in the storage cabinet with the distal end hanging freely. Make sure that the insertion tube hangs vertically and as straight as possible.</p> <p>Review of the AORN standards of practice: Cleaning and processing endoscopes, recommendation V, revealed the following: 2. After processing, hang endoscopes in a</p>	A 951		

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A 951	<p>Continued From page 26</p> <p>vertical position to facilitate drying. Store them in a manner that protects them from contamination.</p> <p>On 3/30/09, the water system that is connected to the endoscope reprocessor was reviewed with the surgical services director and the endoscopy procedures charge nurse. The system was noted to have a filtration system in place that supplies the endoscope processor. The system was observed to have two filters in place, a 0.5 micron and a 0.1 micron.</p> <p>On 3/30/09 at 10:50 AM, the endoscopy charge nurse was interviewed related to routine maintenance of the filtration system and reported that the endoscope reprocessor water supply filters are changed about once per year or sooner if they become clogged.</p> <p>The filter manufacturer's service representative was interviewed on 3/30/09 at 11:15 AM, and reported that the filters are to be changed at a minimum of every six months, and that filters may need to be changed more frequently depending on the number of cases performed, and the quality of the water supplied to the filter.</p> <p>On 3/30/09 at 2:05 PM, a surgical procedure was observed. During the procedure a light cable, which was connected to a light source and turned on, was observed to have been lying directly on the patient's surgical drape.</p> <p>The surgical services director was interviewed and reported that the surgery services department follows the Association of PeriOperative Registered Nurses (AORN) standards of practice.</p>	A 951		

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A 951	<p>Continued From page 27</p> <p>Review of the AORN standards of practice related to fire safety in the operating rooms revealed the following: Fire Risk - Ignition Table, Ignition Sources, read:</p> <ul style="list-style-type: none"> - Place the light source away from items that are flammable. - Do not place a light cable that is connected to a light source on drapes, sponges, or anything else that is flammable. <p>On 3/31/09 the operating room suites were toured with the surgical services director. When asked what the relative humidity was in operating room, he replied "I don't know, bioengineering controls that." The facilities manager was interviewed and reported that the humidity was controlled centrally to all of the operating suites, and that bioengineering monitors the the levels on an ongoing basis. The facilities manager provided a graph of the humidity levels for the operation suites. The relative humidity was noted to be between 12% and 26 % (recommended 30-60%). The facilities manager reported that the humidity sensor was not functional on 3/30/09, and that the humidity levels could not be monitored. The facilities manager provided trending reports and was able to correlate drops in humidity to the operating room doors being kept open.</p> <p>On 3/31/09 at 11:00 AM the sterile supply room was toured. Surgical instruments that were ready for use, were found to contain water marks and were marked with a marking pen on the plastic side of six processing pouches.</p> <p>On 3/31/09 at 11:00 AM the central processing coordinator was interviewed and reported that the six pouches that had water marks should have been reprocessed. She reported the pouches are</p>	A 951	<p>Facilities Manager is responsible for immediate and follow up action as follows:</p> <ul style="list-style-type: none"> a) Service requested by vendor with computer software for trouble shooting humidity sensor's. b) Trend report verified sensor had fault after OR cleaning 0100 3/27/09 approximately. c) Service to AHU #8 control logic and humidifier sensor repaired and adjusted 3/31/09. d) Humidity continued to be checked by Watch Engineer and energy management systems. e) Humidity is per specifications set by sensor and requirements. <p>7-7-09 Facilities manager has Ultimate responsibility for the above and any follow up monitoring</p>	

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A 951	<p>Continued From page 28</p> <p>marked with a marking pen to identify the instrument quickly.</p> <p>The processing pouch manufacturer's representative was interviewed and reported that the pouches should be reprocessed if they contain water marks after processing. He further reported that the pouches should never be marked except for the seal. He reported that marking of the pouches was not recommended and that a record card should be placed in the pouch to identify each processed item.</p> <p>Several double peel packed pouches with sterile instruments ready for use were observed. It was noted that the inner pouch was folded inside of the outer pouch.</p> <p>The central processing coordinator was interviewed and reported that the facility had a limited supply of pouch sizes and that not all of them fit without folding.</p> <p>The processing pouch manufacturer's representative was interviewed and reported that the pouches should not be folded. He further reported that double wrapping items was not recommended. He reported that if an item required double wrapping, the inner pouch must fit inside of the outer pouch without folding the inner pouch to ensure proper sterilization.</p> <p>A tour in the Obstetrical (OB) department on 3/31/09, confirmed that the delivery room contained a Steris autoclave. The OB technician did confirm that the OB department was required to have an autoclave available to sterilize instruments if needed in an emergency, but she</p>	A 951	See previous response on page 21		

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A 951	Continued From page 29 could not recall when it was last needed for an OB need. The OB technician has been in this position for over eight years. The OB technician confirmed she performed weekly biological tests to confirm the autoclave was functioning. The OB technician also confirmed that this autoclave was used as a back-up for the surgery department, and was used on 2/13/09, to sterilize some operating room instruments. An inspection tag present on the autoclave showed it was last serviced on 7/30/08, and was due to be serviced in 10/2008. The OB technician did not know why it was not serviced. The Clinical manager for OB and the Steris representative confirmed by telephone on 4/1/09, that because this autoclave was not used, it had been removed from the quarterly service contract. The OB technician was to report any malfunctions with the weekly tests, and then it would be serviced. The OB technician confirmed in an interview on 4/1/09, that she was unaware that this particular autoclave needed to be flushed daily per manufacturer's recommendation because it contained it's own steam generator.	A 951	Upon identification by surveyor, immediate action taken by OB Manager and manufacturer recommendations from flushing daily was implemented. OB Manager has reviewed and revised the "Biological Monitoring of Autoclaves" policy with changes that reflect manufacturer's recommendations to flush daily because (since moving to new facility) unit has it's own steam generator. The policy has gone thru the approval process and policy is effective June 18, 2009. OB Manager has delivered the policy to all staff in the department and has posted the policy in the OB tech workroom. Weekly biological tests along with daily flushes will continue by the OB tech. Malfunctions/problems will generate a report to Steris and subsequent servicing by manufacturer.	
A1154	482.57(a)(2) ADEQUATE RESPIRATORY CARE STAFFING There must be adequate numbers of respiratory therapists, respiratory therapy technicians, and other personnel who meet the qualifications specified by the medical staff, consistent with State law. This STANDARD is not met as evidenced by: Based on a review of Respiratory therapy policies and procedures and interview with the Respiratory manager, the medical staff have not	A1154	7-9-09 A 951 OB manager has ultimate responsibility for monitoring 7-10-09 A1154 Respiratory Manager submitted Respiratory Department policy/procedure manual to Chief of Staff for medical staff review and approval. Manual includes policies that address adequate staffing and qualification of therapists, technicians and other personnel, that meet/are consistent with	

Medical staff and state law -
Evidence of completion: Chief of Staff signature on Cover sheet in manual by July 17, 2009.
Respiratory manager has ultimate Responsibility for continued monitoring and compliance.

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A1154	Continued From page 30 specified the qualifications of the respiratory therapy personnel. Findings include: The policies lacked documented evidence of qualifications specified by the medical staff for the respiratory therapists, and an interview with the manager on 4/7/09, confirmed that there was no record of medical staff approval for the personnel qualifications.	A1154	All policies and procedures in the Respiratory department are reviewed by the department Manager, Director, and Medical Director. The Medical Director is an appointed Medical Staff Director for the hospital and provides services in a voluntary capacity. This role is documented in the medical staff policies and procedures, policy #MS0020, "Medical Director".		
A1160	482.57(b) RESPIRATORY CARE SERVICES POLICIES Services must be delivered in accordance with medical staff directives. This STANDARD is not met as evidenced by: Based on a review of Respiratory therapy policies and procedures and an interview with the Respiratory therapy manager, there was no record of medical staff approval for the Respiratory therapy services. Findings include: The Respiratory therapy manager confirmed during an interview on 4/7/09, that there was no documented evidence of medical staff approval for the Respiratory therapy services.	A1160	All FTE's in this department are licensed by the States Board of Medical Examiners. The departments FTE's are based on time weighted allocations called (RVU's). Policy 7181-502, "Staffing". A1160 The department has an appointed Medical Director for Respiratory Therapy who is a licensed physician who has a special interest and knowledge in the diagnosis and treatment of respiratory problems. Credentials documented per Medical Staff reappointment for in Medical Staff services department. He is further listed as an appointed Medical Director by the medical staff at Carson Tahoe Regional Healthcare for Pulmonary Services on the Medical Staff committees/ Leadership directory June 1, 2008 to May 31, 2010. 7-10-09 A1160 Respiratory manager has Ultimate responsibility for Policy/procedure manual submission to Chief of Staff for medical Staff review and approval.		

Evidence of Completion: Signature
on Cover Sheet by Chief of Staff
by July 17, 2009 demonstrates
medical staff approval for the
Respiratory Therapy Services.
Respiratory manager ~~will~~ has
ultimate responsibility to monitor

not